Depression

Diagnosis and suffering as process

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Depression: diagnosis and suffering as process

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Abstract

The high rates of depression - as well as the widespread diagnosis of depression - are both controversial and contested in contemporary late-modern society. Issues of flawed definition have been voiced to account for the bourgeoning rates of depression and the diagnosis has been subject to criticism of medicalization and pharmaceuticalization. Others have stated that the actualization of depression is to be seen in light of societal and structural transformations. Be that as it may, depression is affecting more and more people and the diagnosis is prevalent. In this context, a more nuanced understanding of how people relate to, experience and ascribe meaning to their suffering as depression and being diagnosed as such is needed. This article draws on qualitative interviews from Denmark and Norway to explore lay accounts of depression in contemporary late-modern society. The findings reveal that lay accounts of suffering, including living with the diagnosis of depression is a dynamic process, meaning that people vacillate in and out of various perspectives of suffering and categorization to make it fit their specific life situation and prospects of the future. In this article we thus highlight the perspectives of thoroughly analyzing suffering and the diagnostic experience by applying the overall concept of process, which takes on different meanings in the course of the analysis.

Keywords: *Depression, diagnosis, suffering, process, career, late-modernity*

Introduction

It seems fairly uncontroversial to claim that diagnosis has always played a crucial part in modern medical practice (Rosenberg, 2002). As both category – and hence the agreed upon definitions of pathological conditions by the medical profession – and process, that is, the procedural application of these labels (Blaxter, 1978), diagnosis has been an invaluable instrument in doctors toolbox. In contemporary late-modern society, however, diagnosis has transgressed the boundaries of medicine and has come to play an important role within the realms of academic research, economics, politics, culture and the professional organization of welfare state allocations. (Rose, 2015). This development has helped to pave the way for – and perhaps even necessitated - a new academic branch, namely the sociology of diagnosis (Jutel, 2011). According to its proponents, this type of sociology has to relate actively to the altered status of diagnosis in contemporary society and therefore occupy itself with the structural and individual effects and consequences thereof. In fact, one could say that diagnosis *per se* have become a prism through which we are able to understand important aspects of society. As Charles E. Rosenberg remarks:

> Diagnosis is a cognitively and emotionally necessary ritual connecting medical ideas and personnel to the men and women who are its clients. Such linkages between the collective and the uniquely individual are necessary in every society, and in ours the role of medicine is central to such negotiated perceptions and identities. The system of disease categories and diagnosis is both a metaphor for our society and a microcosm for it (Rosenberg, 2002, p. 256).

It is our assertion that this is particularly noticeable with reference to the diagnosis of mental disorders. As the organization of diagnosing mental disorders are reflecting specific historical circumstances (Grob & Horwitz, 2010) rather than being based on clear-cut bio-markers, they are displaying socio-cultural frameworks through which, in particular, the relationship between the normal and the pathological can be discussed and understood. The diagnosis of mental disorders and their ramifications can therefore not be comprehended without reference to the times in which we live.

Although this is the case, no consensus in understanding why particular psychiatric diagnoses are actualized more than others is achieved. Perhaps the diagnosis of depression – and hence the symptoms used to describe the diagnosis – is one of the most central diagnosis we have that describe what counts as normal and pathological in contemporary late-modern society. But

how do we understand its proliferation? French sociologist Alain Ehrenberg offers one explanation. In his historical analysis of why the diagnosis of depression has become so proliferated in contemporary society, he argues that this is due to the symptoms of depression being so radically different from ideals of normalcy that individuals should strive for. The diagnosis of depression therefore represents the outmost categorization of which human traits that are unwelcome and even handicapping, whereby the conclusion must be that "the depressed person stands in exact opposition to our social norms" (Ehrenberg, 2010, p. 233). In *The Loss of Sadness*, Allan V. Horwitz and Jerome Wakefield offer another explanation of how the bourgeoning rates of depression in contemporary Western societies can be understood. Their main claim in the book is that ""the Age of Depression" results from a faulty definition of depressive disorder" (Horwitz & Wakefield, 2007, p. 6). What they argue is that the explosion of putative depressive disorder does not stem from a real rise in this condition but has been made possible by a faulty definition of depression in the DSM-IV in which the categories of depression and sadness have been conflated. In their perspective then, the percolation of a wrong understanding of depression into clinical practices and everyday life by a diagnostic manual – presumably leading to medicalization - is to blame for the proliferation of the diagnosis of depression. Despite the value of Ehrenberg and Horwitz and Wakefield's rivalling explanations of the epidemic proportions of depression, they have surprisingly little to say about how depression as the preferential form of human suffering in the 21st century plays out in people's life-biographies.

For as David A. Karp has written in his award-winning book – *Speaking of Sadness*[1] – no matter how one understands *why* the diagnosis of depression thrives in contemporary society, one has to take into account *how* real people get the diagnosis and hence live with the related real symptoms (Karp, 1996). Thus, the study of the diagnosis of depression should not only focus on the societal conditions of this diagnosis *per se* nor on the medicalization of the disorder but (also) on those women and men behind the description who are enduring the suffering. Questions about how people relate to, experience and ascribe meaning to their sufferings as depression and having the diagnosis are therefore of interest. This is the perspective we take in this article. Hereby we are following in the footsteps of numerous researchers, for example Karp (1994) and Kokanowich, Bendelow and Philip (2013). But whereas Karp's study focuses on how living with depression represents an identity turning point for those who suffer, and Kokanowich et al. focus

[1] Perhaps, although admittedly somewhat speculative, there is something telling in the way in which Horwitz and Wakefield and Karp relate differently to the concept of sadness. Whereas the former believe sadness has been lost during the way of growing influence by diagnostic psychiatry, Karp insists that sadness is still important to analyse and discuss because real people experience sadness – and continue to do so.

their study on the ambivalence that occurs for those receiving and living with the diagnosis, our focus is somewhat different. First of all, we are not limiting our study to either the diagnosis or the suffering from depression: We focus on them mutually. Secondly, the analytical prism through which we analyze our interviews is process driven. The concept of process is, of course, very broad and varied in relation to different subject matters. In relation to our analytical purpose, the concept of process is qualified and supported by adapting and molding it into specific theoretical perspectives, hereby adjusting it our field of research. That is, via thorough readings of our interviews we discovered that process – in various ways and understandings as we shall show – is a central component of both getting, living and suffering from depression. In fact, what we show is not one single process but several processes related to suffering from depression and getting the diagnosis.

In order to explicate this, we shall proceed in five steps. Firstly, we describe the methodological approach we have taken. Secondly and thirdly we analyze how process is a central tenet of suffering from depression and living with the diagnosis. Fourthly we discuss our results and elucidate why further research is needed before we fifthly – and lastly – conclude on the main points of the article.

Methods

The empirical material we are presenting in this article stems from two interview studies – one with nine young people between the age of 19 and 29 in Denmark and one with seven young adults ages from 20 to 31 in Norway.

The interviews in Denmark was part of a larger study (*The Diagnostic Culture Research Group*), and took a particular interest in how young people in contemporary society relate to their diagnosis of depression and how they cope with and handle a depression whilst at the same time tried to maneuver in the landscape we commonly refer to as youth years. The overarching thesis of the study was that young people struggle with the difficulties of managing a depression and relating to the diagnosis in a different way than other age groups because they find themselves at a crossroad in life, where questions of identity, education, sexuality, family-formation and friendship present themselves in an exceptionally pressing manner. That is, the combination of being young and having a (diagnosis of) depression was perceived to be unyieldingly influential on these life-matters. And they were, as we shall see later in the analysis.

The Norwegian interviews was part of the psychologist Linn Julie Skagestad's[2] master thesis work (cf. Skagestad, 2014; Skagestad & Madsen, 2015) that investigated how the emergence of depression in the 21st century is possibly linked to defining features of late-modernity, like increased complexity, de-traditionalization and individualization, that may upset young people's subjectivation, well-being and mental health. The hypothesis was that a perceived failure to live up to the normative standards of the contemporary Western neoliberal culture of the sovereign, self-governing individual, ideally in control of every aspect of his or her biography, can result in depression. A thematic analysis of the interviews partly confirmed this, but also demonstrated that perhaps more personal unique themes like experiences of bullying or genetic dispositions for depression must be integrated with more overarching sociocultural explanations of depression.

Eight out of the nine informants in the Danish interview study were women, while five of the seven participants in the Norwegian study were female, underscoring the existing skewed gender prevalence in the diagnosis of depression (cf. Abate, 2013). However, in this article this perspective is not taken into consideration as it is considered analytically irrelevant for the principal research question. In order to solicit informants, the main researcher of the Danish study placed an advertisement at the student internet platform at Aalborg University – a strategy that yielded a large number of responses. However, when being contacted, some members chose not to participate in the study, leaving nine participants all of which were undergraduate students at Aalborg University. The interviews were conducted by the main researcher in settings at university campus in Aalborg or in locations nearby. In the Norwegian study five of the informants were students enrolled at the Oslo and Akershus University College of Applied Science and the University of Oslo, while two were pupils at one of Norway's folk university colleges. They were recruited through a public advertisement poster and through the administration of their place of study which shared information about the research project to their students by email. The interviews were carried out by the master student in appropriate settings at the Department of Psychology at the University of Oslo. Both sets of interviews were semi-structured (Kvale & Brinkmann, 2009), lasting between one and three hours.

As noted by various scholars, mental health among university students represents a growing public health concern (Eisenberg et al., 2007, p. 534). Depression is one of the disorders that focus has been directed at, thereby affecting the overall discussion about the socio-structural factors involved in getting a depression. In other words: Is depression becoming just as prevalent

[2] Ole Jacob Madsen would like to thank psychologist Linn Julie Skagestad - who conducted the Norwegian interviews - for giving her permission to use them here.

amongst people with higher levels of education as it is traditionally the case with people who have little or no education (cf. Brown & Harris, 1978)? We shall return in the discussion to whether their educational status has influenced their responses in the interviews.

Suffering from depression as a process

A useful conception in developing an analysis of the often dynamic nature of depression seems to be that of "process". Within the sociology of health and illness there has been a long tradition of using the concept of process in relation to the study of stress. A pioneer in this field is Leonard I. Pearlin, who coined the term "the stress process" (Pearlin et al., 1981). According to Pearlin "the process of social stress can be seen as combining three major conceptual domains: the sources of stress, the mediators of stress and the manifestations of stress" (Pearlin et al., 1981, p. 337). As the quote indicates, the main focus is on the process of social stress, without losing touch with some of the more individual causes. Thus, considerable interest in particular life events (getting a divorce, involuntary job disruptions etc.) or in chronic life strains (economic hardship, living in a ghetto etc.) (cf. Aneshensel, 1999; Dohrenwend, 1973) and in which mechanisms – coping strategies and social support – that could mediate the impact of these stressful circumstances, has been shown. According to Pearlin, however, not enough interest has been placed in investigating the interconnections between these various components of stress and how they form a process of stress. It is not within the scope of this article to transform this model in its entirety to the study of how suffering from depression can be seen as a (social) process. It is, however, possible to make use of the concepts offered in our analysis of the empirical data. By doing so we believe important and nuanced light will be shed on how suffering from depression involves various – and often intertwining – components.

Sources of depression

In their classical study *The Social Origins of Depression* George W. Brown and Tirril Harris (1978) traced the social sources of depression – particularly among women – to various boundaries of society, its socio-economic structure, cultural climate and developmental tendencies per se. However, focus was also on eventful individual experiences and particular life strains that paved the way for the internalization of depression. Hence, the interconnection between these three aspects was pivotal in their analysis of the sources of depression. In more recent empirical studies of depression, this modus vivendi has more or less been followed (cf. Karp, 1996). So then, in which way do the informants in our study trace the sources of their

depression to these components? In the interviews with the young people in Denmark and Norway, there is no doubt about the fact that most of them relate their depression to the cultural climate in contemporary society – more precisely to the normative demands of realizing an idealized self (see also Petersen, 2016; Skagestad & Madsen, 2015). As Catherine[3], a woman of 24, stated when asked if she believed other things than strictly personal triggered her depression:

> Yes. There are a lot of demands that you have to be like this and that. That you have to be a special person, for the labour market etc. But what if you cannot be that person? What if you are not capable of being like this? Then you are simply just a loser. There is no room for people who do not want to compete and who do not want to be a career person.

Whereas 31-year old Line stressed how the ideal of being your optimal self both serves as an internalized and externalized norm that surges pressure:

> We have (…) every possibility ahead of us. Therefore everybody around you expects you to be the best version of yourself, because it is feasible. There is an enormous amount of pressure on young people. [Our translation] (Skagestad & Madsen, 2015, p. 759)

The other informants, besides one, stated something similar to Catherine and Line. Henry, a 24 year old male, described how the pressure of getting good grades and socializing in the right way supported the internalization of his depression. While Monica, a 22 year old woman, stated that constant pressure to perform and be a young successful woman most certainly was a contributing factor to her suffering from depression. Iben, a woman of 27, backs this line of argument by describing how

> being young is stressful. Again, because so many things are thrusted upon us from above (society ed.). What you have to do and what not to do. There are so many demands about what you have to do…so I think it is stressful and perplexing.

The 24-year old Thomas statements, adds to the fact that, although depression is most prevalent among women, men are not unaffected by these norms either: "One shall accomplish things. That is important for me, for my self-actualization. If I don't achieve, I feel guilty when I go to bed at

[3] All the names are fictional and the quotes have been translated by the authors.

night, with a feeling of having thrown the day away" [Our translation] (Skagestad & Madsen, 2015, p. 758).

Nevertheless, these components – however important they might be – were not to blame entirely for the instigation of their distress. The respondents did not adhere to a single explanation when structuring the entirety of their experience of depression. This is in line with most characterizations of so-called exploratory maps, whereby

> in seeking meaning individuals may hold various explanations simultaneously or they may move rapidly from one belief to another. The process of seeking meaning is therefore characterized by movement and uncertainty (Williams & Healy, 2001, p. 473).

Movement, of course, refers to the intrinsic dynamism in persistently trying to come to terms with one's depression. Uncertainty, on the other hand, relates to the ongoing reflexive process of finding various chunks of meaning in one's depression. Therefore, in relation to our respondents, focus was also on specific individual experiences and stressful life strains that contributed to their depression and hence in mitigating how their depression made sense.

Individual experiences and life strains

As the respondents did not subscribe to one single explanation of their depression – stressful societal conditions could not amount to the whole story - they typically called attention to a diversity of possible explanations. That is, Catherine mentions a continuous alteration in her moods that she believes she is born with; a strenuous relationship with her parents and a personal straining experience at a folk high school. Likewise, Thomas attributes his bouts of depression with serious back problems that affected his ability to study which caused him to feel unmotivated and a failure, while also admitting he viewed his depression as an inherent genetic disposition. In the Norwegian sample several informants also pinpoints how moving from their home place to a larger city like Oslo made them particular vulnerable, like 21-year old Bendik that feels he has let himself down by not exploiting his new life in the big city enough, on top of problems relating to coming out of the closet that is difficult in the conservative Christian environment he grew up in. Monica mentions the ongoing moving from place to place when she was a kid, which made her feel homeless; an irreversible illness of her father that left her overburdened with responsibility at home and a case of what she refers to as "mild" bullying at high school. Sumaira stresses that she suffered ten years of bullying that caused her to fail at school and develop a serious depression, but she later felt rushed by the psychologist she saw and

felt she had to pretend to be better in order to keep her therapist happy, which made things worse. What is significant is the fact that the mentioned experiences were not perceived as separate blocks, each caring its part of the burden, but rather, retrospectively, perceived as something that intensified each other and thereby paved the way for the depression. The accumulation of these, one could argue, created sufficient strains to trigger and settle the depression.

As the suffering of depression is internalized – in the sense that it is acknowledged and recognized - almost all of the respondents sought help in mediating resources: Social support or coping strategies. It is common sociological knowledge that social support (being loved and appreciated by ex. family members or colleagues) and coping (strategic use of tools of management) – are powerful buffers or help against depression (Turner, 1999, p. 200). That is not to say, however, that neither social support nor coping could hinder the depression. But it is to say, that the respondents underwent this process when trying to tackle their depression. Parents and siblings were often used as sparing partners – some more successful than others. Some of the informants highlighted the absence of people around them as key in the onset of depression, like Bendik who felt deserted by his parents when he moved out from his childhood home. Specific strategies – such as adapting ones expectations about the outcome of life to the situation with depression and withdrawal from particular social events – were used. These strategies, to a large extent, helped the respondents to clarify future expectations in life. That is, some of them did actually not alter their hopes and desires. As Karin, a woman of 28 stated: "I am just as ambitious as I have always been. My depression has not changed that". Karin is an exception, however. The majority of the respondents adjusted their goals in life according to their depression, without accepting the depression to determine their life. Not a single one of the respondents thought that the depression would be a straightjacket in their life forever[1], although pieces of it might follow them throughout their lifetime. In other words: The depression was not a hundred percent in charge of them. In that sense not only living with a depression but also trying to alleviate oneself from the strains of depression can be seen as a constant process. Inherent in this process is the ascription of meaning to the depression. That is, the way in which the respondents search for meaning and tries to make sense of their depression (Lewis, 1995) has to be seen as a very dynamic and ongoing interpretive process to which a specific understanding of time is attributed. The suffering from depression is caused by something in the past which inflicts on and generates the distressful situation they are in now. This makes sense. That does not entail, as mentioned, that the distress will follow them into the future. Hence, ascribing meaning to the depression does not necessitate that they perceive the depression as meaningful per se. They do not see

themselves as people living with depression, at least not if that involves accepting that the depression will follow them for the rest of their lives.

As Karp, very insightfully, has written, suffering from depression involves a number of identity turning points (Karp, 1994). Ones identity as a depressed person, then, is by no means static or linear but rather complex and changeable. Identity in this sense concerns the relationship one has with other people – and is hence inter-subjectively constructed - and materials, but also with time sensitive coordinates. In relation to our respondents, the identity of the present is not transported into the future. They are very aware of the fact that many turning points can occur, thereby altering their situation. They can meet new friends and interlocutors; new treatment can be invented etc. Hopefully this will change things for the *better*. And hope is required. Because, as Karp (1994) hints at, an identity turning point can also go in the wrong direction. Things can actually get *worse*.

Diagnosis of depression as a process

In a famous article, which we have already made reference to, Mildred Blaxter distinguishes between two aspects of diagnosis, that is 'category' and 'process' (Blaxter, 1978). What she refers to as process, however, is limited to the process by which doctors give patients their diagnosis. That is, the way in which doctors handle the diagnosis, the examinations they have to go through etc. before the patient receives the diagnosis. Without neglecting this aspect of the diagnostic process, we would like to direct attention to another process of getting, living with and ascribing meaning to the diagnosis. In order to do so, we employ the concept of 'career'. Famously, American sociologist Howard S. Becker used this concept to study and understand deviant outsiders. As he writes, the concept was originally:

> developed in studies of occupations, the concept refers to the sequence of movements from one position to another in an occupational system made by any individual who works in that system. Furthermore, it includes the notion of "career contingency", those factors on which mobility form one position to another depends (Becker, 1973, p. 24).

Becker used an altered version of this model to study a particular kind of deviant behavior, namely the use of marihuana (Becker, 1973, p. 59-72). In doing so he also reflected upon some of the problematic aspects of the concept, for example the inherent idea of a 'career ladder'. Careers do not always follow a linear path and are hence not to be understood as something that always

moves forward in a progressive manner. Moreover, some people also have more or less fleeting contact with deviance and do hence not follow a career path per se. As Becker notice, becoming a regular marihuana uses implies the internalization of various techniques that have to be learned. For example, one has to learn to perceive the effects, learn to enjoy the effects of marihuana etc. (Becker, 1973, pp. 48-58) as part of ones career to becoming a regular, and hence deviant, marihuana user. But some people, though they set their mind to it, do not learn that. Like alcohol consumption, the effects are not to everyone's linking. And some people do not want to learn it – they just want to have a quick "flirt" with marihuana without becoming regular users. These aspects are also something we take into consideration when we transform this analytical model for use in the study of diagnostic careers. For example, we do not confine our interest to linear careers, but also consider more complex careers in the diagnostic process. Diagnostic careers can, as we will show, follow different pathways and go through various phases. One pathway is that of "slow movement". In this case the career progresses, but at a very slow – and rather unsatisfying - pace. Another pathway is that of reducing bumps in the road. That is, the diagnostic career precedes fairly smoothly enabling improved personal understanding and intersubjective communication. A third pathway follows that of a pendulum. That is, it swings back and forth between positive outcomes and negative contemplations.[2] Let us dive into the data.

Henrys diagnostic career began at lower secondary school. Before he reached the eighth grade, things were just fine. He thrived in school and with friends. But after having started in a new school, what Karp (1994) would refer to as an identity turning point, Henry became more and more isolated and marginalized from his classmates and from his social environment per se, leading to an experience of loneliness. At high school, things started to fall apart. He states: "In high school I began to fall to pieces. I struggled to manage my way through classes because I was unable to concentrate…so I became depressed during this ride". The "ride" Henry refers to is actually leading him towards a standstill – the depression. This is how he relates to his distress – a full stop, or a black hole that is very difficult to climb out of. One way of dealing with the effects of feeling stuck was to consult a doctor and finally get the diagnosis of depression. But that did not happen before the last year of high school, meaning that Henry struggled with the symptoms of depression in about four years before he was diagnosed. The first step in his career – leading up until the diagnosis - was not only filled with distressing symptoms but also with insecurity about what he was going through. For Henry, getting the diagnosis was a relief, albeit a short lasting one. He quickly realized, as it also noticed in other studies (cf. Ratcliffe, 2015), that the diagnosis did not relieve him from his symptoms. The diagnosis, in that sense, was not a magic bullet. It did, however, lead him to the next stage in his diagnostic career, namely towards

getting pharmaceutical treatment. Henry, in his current situation, is not particularly happy with this treatment. He does not know, though, what else to do. He feels as if he is stuck – once more – on this path of struggling with the symptoms of depression and allowing the diagnosis to serve as a gatekeeper to new treatment. In that respect, his diagnostic career is only slowly progressing.

For Rebecca, a woman of 24, the story is a bit different. Her diagnostic career began when she was around 15-16 years. I that period of her life she struggled immensely with her sense of self as a teenager who had a hard time finding her right place amongst her peers. That resulted in feelings of massive discomfort that wrecked her. In the interview she refers to those feelings, metaphorically, as "breaking down". At that time, however, she was not diagnosed. Three years prior to the interview she went through another period in her life of gradually breaking down. That period, she mentions, is filled with turbulence: New surroundings; loss of friends; new education; a lack of significant interlocutors etc. The result of these aspects in her life, Rebecca says, is amounting feelings of insufficiency and loss of self-worth. Though it takes a toll on her, she is not willing to accept the fact that she is suffering from something that she cannot control. She refers to herself as a fighter who believed "a good kick in her butt" would suffice to get her back on the right track. Asking someone else for help would not be acceptable – it would be a great personal defeat. Luckily, she says, a guidance counsellor advised her to see a doctor – the same doctor who diagnosed her with depression. Getting the diagnosis actually made a huge difference for Rebecca. After getting the diagnosis, she states:

> I began to relax a bit more, that is, I began not to pressure myself as much as I had done previously. I began to accept that this is how I am. And to accept that it is ok to get help. My psychologist was very helpful in this respect. That I had to accept things the way they are. So yes, I think I became calmer this way.

The diagnosis, then, brought about acceptance, and it instigated better knowledge about herself. It is as if the diagnosis gave Rebecca a new pair of looking glasses that she saw herself through. In her current situation she is not afraid of realizing that she cannot be as perfect as she might wish – not get as good grades as she would have preferred. She does not, to a large extent due to the diagnosis, blame herself for her lack of good grades, for example. She now knows why she cannot perform to achieve better results. The diagnosis is the objective evidence that legitimizes her difficulties. That is not to say, however, that she uses the diagnosis as an excuse. Rather, she perceives it as an explanation (see also Brinkmann, 2014). Also, a vital part of her diagnostic career has been her open attitude towards telling other people about her depression. She feels as if

the diagnosis serves as a positive point of entrance to her conversation with other people about her depression.

Rebecca partly links her positive experience with getting the diagnosis with the process in which she got it. The doctor took time to examine her in great detail, not just subjecting her to standard tests or questionnaires. The doctor, she states, actually "acted as if she really cared about me". Thus, Rebecca did not feel as if the doctor was forcing the diagnosis on her, nor did she try to shove a particular treatment down her throat. She enlightened her about what options she had and guided her in making decisions. First, Rebecca decided to undergo psychological treatment, but gradually she chose to use antidepressants. She is quite comfortable with these choices, although she is somewhat worried that she has to undergo treatment for the rest of her life.

Whereas Karianne's, 27 years of age, narrative of depression shows how it often is perceived as complex process that draws on environmental and heritage triggers that we previously has seen, and diagnostic careers features both peers and professionals as distinctive and relieving characters. Karianne tells a story of how she never belonged to the "cool gang" when adolescent; while simultaneously being exposed to much unrest among her parents (Skagestad & Madsen, 2015). She got an eating disorder when she was 16, but first got diagnosed with 'classical depression' when she was 22, after struggling to fit in with her new network in Oslo. Once again she failed to be one of the cool; the acceptance of failure was low, and Karianne felt she could not share her gloominess with them. She then started seeing a psychologist and took some distance from her gang. Last year she experienced a break-up with her boyfriend who had helped her overcoming her depression and eating disorders, but now everything fell apart again. Her doctor first instructed her to talk to a psychologist, that initially gave her a slight upturn, but it was not enough and Karianne went to her GP and got him to write out the antidepressant Cipralex. After a few days she felt she could breathe again. Having read a lot about depression recently she now wonders whether she is a little bit hereditary charged. Karianne's diagnostic career seems to surge back and forth, and her depressed identity is seemingly most present when her social support fails and professionals "take their place".

As shown, an important aspect of one's diagnostic career is getting treatment. In the cases of Henry, Rebecca and Karianne – as it is the case of the majority of the other respondents – the treatment is (first and foremost) medicinal. Various kinds of antidepressants have been prescribed to the respondents. Whether or not they feel satisfied with this treatment, it seems fair to claim that they are inscribed in what psychiatrist David Healy has coined "The antidepressant Era" (Healy, 1997). By using this term Healy wants to direct attention to the fact that the combination of diagnostic categorization (as the preferred answer to depression in contemporary society) and

pharmaceutical treatment seems to be a perfect match. In Healy's understanding, these aspects have been intertwined to such an extent that they have settled in society as the right combination – that antidepressant medication is the answer to the question of depression. The societal settling of the medicalized answer to depression is, of course, the result of a specific historical process (Healy, 1997, p. 50). An important consequence of this is that a diagnostic career more often than not entails the consumption of antidepressants. Our respondents then, cannot free themselves from being weaved into a web of structurally predetermined notions of which treatment their depression would benefit the most from. This has, without a doubt, an important impact on their diagnostic career.

Diagnostic careers can, of course, be quite similar. They can follow the same pathways and similar directions. But there is absolutely no evidence that suggest that they are completely analogous. What we can state, however, is that all diagnostic careers are always in process in relation to individual specificities. That is, people vacillate in and out of various orientations about their diagnosis in order to make it fit their particular circumstances.

Discussion – why further research is needed

Current debates about why so many people in late-modern society are haunted by depression are important and vital to our understanding of the proliferation of the phenomenon in question. Different voices in this debate have been raised, covering aspects of flawed definition of depression (Horwitz & Wakefield, 2007), a loss of meaning in contemporary society (Blazer, 2005), pathologization of normal human traits (Brinkmann, 2010), an "unhealthy relationship between the pharmaceutical industry and depression" (Healy, 2004) and chronic strains of the performance society (Petersen, 2016) as explanations of the bourgeoning rates of depression. Now, these (sometimes intermingled) explanations are covering important ground – but they do not cover the entire ground. The *how* is often left out when the favored explanations are pointed to. We can only speculate as to why that is, but one hypothesis might be that societal perspectives or critical perspectives on psychiatry, Big Pharma, psychologists etc. often operates under the notion that the depressed are undeserved victims of society or the industry, and therefore maybe leaving the people actually suffering and diagnosed with the illness alone. This may be doing them a disservice. Because as we have strived to show in this article, people are *really* being affected with the symptoms of depression and they are *really* getting the diagnosis of depression. Therefore, one has to take the ways in which people tackle, ascribe meaning to and experience their symptoms of depression and their diagnosis seriously. By using the overarching concept of process, molded in different ways, we have sought to meet this challenge. We believe this has

enabled us to show some of the very complex nature of suffering with depression and being diagnosed with depression. Perhaps the concept of complexity is of the essence here.

What appears apparent from several of the informants dialectical relationship between depression as suffering and depression as diagnosis is that being diagnosed both can serve as heavier burden than before, but also function as a relief, for instance by giving a proper name to the previous unknown proportions of suffering. Much of the exciting research literature on depression and diagnosis in general has had a tendency either to neglect what the burden of being diagnosed with a depression may represent (cf. Beck, 1979), or exaggerate the negative effects, as if subjugation what happens by default when subjects are diagnosed, and people who report the contrary must be living under 'ill faith' (Sartre) (cf. Horwitz & Wakefield, 2007). Future research on depression and other diagnosis should instead tap into the empirical reality of how people with different modes of suffering, unlike diagnosis and diverse life-situations relate to their categorization. Without formulaic prejudice by researchers that people getting a diagnosis are always helped and empowered or alternatively suppressed and disempowered.

Another interesting aspect for future research, has to do with how people come to master (or not) their suffering and diagnosis like depression is that there is much to learn from how informants attributes different causes towards their depression. Of course the stories the interviewees tell might simply be their individual, "true" story that is more or less accurate, preferred explanations of suffering. Yet even if the initially come across as unique to the individual, they tells us something about contemporary society, the hegemonic discourse(s), and the form Western individualized lives how come to take in the 21st century. For instance, two of the reoccurring accounts in both the Danish and Norwegian sample were periods of bullying in school and depression running in the family genes, could be interpreted as expressions of dominating attribution mechanisms in the present. Either by understanding bullying in simply an individual framework, or a more complex phenomenon that transcends an individual context, involving normative categorizations like gender, ethnicity, identity, and changing cultural presumptions about success and outsiderness (Schott & Søndergaard, 2014). If more people are bullied and depressed as an outcome of less acceptance of ways of being less than perfect or self-realized according to narrower norms – patterns of life-stories from depressed patients could be valuable information for working with prevention on a larger scale. Likewise, expressing ideas about depression running in our genes might be associated with a evident tendency to explain all human relations with genetically and biological descriptions (Vidal, 2009), that may be both be helpful or unhelpful for people suffering as it effectively supports an idea of determinism or even faith.

Finally, why is it that depression looks as if to increasingly affect educated, young Western people, we asked initially? One curious, and perhaps provoking, characteristic with our particular group of informants – students in higher education – in relation to the way they attribute meaning to their depression as suffering and diagnosis, is whether 'being depressed' also has become a cultural acceptable, and even attractive way of identity categorization, as it seemingly gives the message outward of someone with a troubled, but complex inner life. Some even use the term "romanticized depression" to characterize what they perceive to be a trend among particularly well-educated adolescents to positively identify themselves with depression – a trend that has blossomed via the growing impact on the category of depression by social media (Bine, 2013), Of course, a hypothesis like this tends to overlook the severe and immobilizing sides of depression, and risks portraying suffering from depression simply down to individual choice. Another more material possibility is that young Western people, both face an enormous amount of pressure linked to self-realization and self-optimization, while also being confronted with insecure future in terms of getting a relevant job, the security of tenure, paying their monthly rent or loan and so on (although Denmark and Norway are doing fairly well compared to other European economies).

Conclusion

In this article we have argued that despite the contested nature of both depression as suffering and diagnosis in contemporary culture, people's experiences are nonetheless real, regardless of how we have come here. Therefore a more nuanced understanding of people relating to depression as experience and diagnosis is needed. By providing interviews with 16 young adults from Denmark and Norway we analyzed the interview material through the sociological concepts of 'career'. 'category' and 'process', meaning that people vacillate in and out of various perspectives on handling depression, often in a pragmatic manner in order to fit in with their specific life situation. Our results show that the common nominator among our informants is process – people are always in process as their relationship to a categorization like a depression diagnosis is never static, but always in motion. Finally we argued that both sides in debates about the status and necessity of diagnosis often fails to acknowledge this complex relationship, either by neglecting it or paint a too gloomy picture. Future research should therefore focus more on interactive side of depression focusing on how it appears as a diagnosis and experience in individual's lives and in institutional practices and discourses. One the one hand, we know from other diagnostic categories that people sometimes are capable of taking matters into their own hands, negotiating

with their categorization. But on the other hand, that is seemingly the problem with many depressed in the individualized 21st century: too much is simply left in the hands of the individual. The challenge for imminent research is not to underestimate neither, but make sure this difficult paradox is preserved.

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[1] At the time of the interview, our respondents suffered from various degrees of depression. In the Danish material the informants were all diagnosed in the category of either moderate or severe depression and a majority of them were taking antidepressant medication. In the Norwegian material the inclusion criteria for the participants were that they had been diagnosed with unipolar depression at least three months prior to the interview phase.
[2] We do not, in any way, claim to have exhausted all the possible diagnostic career pathways there is.